Commonwealth of Massachusetts **Department of Mental Health**

Telephone Notifications of AWA (check all that apply) (written notification must follow by next business day)

Patient Name: _____ Area: _____ Date of **AWA** Incident: _____

Please initial; give date & time notice is given

☐ Police:

Local: _____ _____ _____
city/town/phone number Contact Person

_____ _____ _____
city/town/phone number Contact Person

_____ _____ _____
city/town/phone number Contact Person

State: (contact person/phone number) _____ _____
Campus: (contact person/phone number) _____ _____
Local (in patient's community): Town/City: _____ _____
(contact person/phone number) _____ _____

☐ Court: Name of Court: _____ _____
Contact Person: _____ _____
Name Phone

☐ DA: County: _____ _____

Contact Person: _____ _____ _____
Name Phone

☐ Next of Kin: Name : _____ Phone: _____ _____
☐ Area Director (or designee): Name: _____ Phone: _____ _____
☐ Legally Authorized Representative: Name: _____ _____
Phone: _____

☐ Person at Risk ☐ Other: Name: _____ _____
Phone: _____

Notifications of Return/Discharge (check all that apply) (Please note whether telephone notification, written notification, or both. Written notification is required by first business day following return/discharge if written notification of AWA was given):

☐ Police:

Local: City/Town: _____ _____ _____

City/Town: _____ _____ _____

City/Town: _____ _____ _____

State: (contact person/phone number) _____ _____
Campus: (contact person/phone number) _____ _____
Local (in patient's community): Town/City: _____ _____
(contact person/phone number): _____

☐ Court: Name of Court: _____ _____

Contact Person: _____ _____
Name Phone

☐ DA: County: _____ _____

Contact Person: _____ _____
Name Phone

☐ Next of Kin: Name: _____ Phone: _____ _____
☐ Area Director (or Designee): Name: _____ _____
☐ Legally Authorized Representative: Name: _____ _____

Phone: _____

☐ Person at Risk ☐ Other: Name: _____ _____

Explain: _____ Phone: _____

Form AWA-1 Instructions: Please print. This form is to be filed in the patient's medical record & appended to the Incident Report.